Standards Implementation Workgroup
Draft Transcript
October 7, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, everybody, and welcome to the Implementation Workgroup. This is a federal advisory committee, so we will have opportunity at the end of the meeting for the public to make comment. Let me do a quick roll call of members. Judy Murphy?

Judy Murphy – Aurora Healthcare – Vice President of Applications
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Liz Johnson?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Lisa Carnahan? Anne Castro?

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Carol Diamond? John Derr?

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Micky Tripathi? Linda Fischetti? Timothy Gutshall? Eric Strom is on for Nancy Orvis.

Eric Strom – DoD Military Health System – Program Management Support
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Wes Rishel? Kevin Hutchinson? Joe Heyman?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Cris Ross? David McCallie? Kevin Tarkoff?

Ken Tarkoff – RelayHealth – VP & General Manager
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay, Kevin. Tim Morris?

Ken Tarkoff – RelayHealth – VP & General Manager

It's Ken, actually.

Judy Sparrow – Office of the National Coordinator – Executive Director
I'm sorry?

Ken Tarkoff – RelayHealth – VP & General Manager
Ken Tarkoff.

Judy Sparrow – Office of the National Coordinator – Executive Director
Judy Sparrow here and Mira Choi. Did I leave anybody off?

Lisa McDermott – Cerner Corp. – Sr. Architect
This is Lisa McDermott, and I'm taking David McCallie's spot.

Judy Sparrow – Office of the National Coordinator – Executive Director
With that, I'll turn it over to Judy Murphy.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I'll turn it over to Liz. Does everybody have the agenda in front of them, because Liz was just going to quick run through the agenda?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
The one thing Judy and I would like to do before we start though is, Tim, you're a new member to your group. Would you like to introduce yourself to us? We're really glad to have you.

Tim Morris – Emory University – Director, Research Informatics
My name is Tim Morris. My background is I was at the CDC for a number of years, about 20 years, half of it in laboratory science there, and then the other about 10 years in public health informatics. I was director of the division of informatics shared services there and the national center for public health informatics. About 2 years ago, 2.5 years ago, I left, and I joined Emory University, so that's where I am now in the research and health sciences IT.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Great. Welcome. I know the group is glad to have you. We certainly are.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
I just wanted to tell you a change in my status, if that's okay. I'm going to chairing a national physician advisory board for Ingenix.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Welcome, everyone. Quickly, I'll go through the agenda, and then we'll continue our meeting. We have about an hour and a half today. Again, as we've said in the past, we'll be very cognizant of people's time, as well as opening it up for the public for comment. What we plan to do today is have Judy present to you both the summary and then the way that summary was presented to the HIT Standards Committee. I think you'll find it very thorough.

Then we want to talk about some ideas we have around having a hearing in January of 2011 and sort of get from the group some input into how that might be both characterized, and the type of participants who might want. Then really talk about sort of one of our major goals, which is how do we make absolutely sure that we're doing what we can to make sure implementers have what they need. So I think that's very important. Then we'll summary what's the meeting, what we've decided, and where we'll go from here because we'll be putting together another summary document that will be presented to the HIT Standards Committee on the 27th of October. Then we'll open it up for public comment prior to closing the meeting.

Any questions about our agenda today? Hearing none, Judy, do you want to run through the presentation for us?

Judy Murphy – Aurora Healthcare – Vice President of Applications

In addition to receiving the agenda, as a Word document, you should have received a PowerPoint slide deck as well, which had just eight slides in it. What we did when we gave our update at the September 21st standards committee was ran through the new workgroup member list, and that's slide two, and then the charge of the group and a list of our current and future meetings. Actually, our meeting was on the 15th and the report … that I'm describing was on the 21st. I had that mixed up a little bit.

But what I wanted to draw your attention to was really the preliminary list of potential activities. There are four slides that summarize, in a hopefully succinct fashion, the conversation that we had during our last meeting on the 15th. I think many of you were able to participate in that. It wasn't easy to pull that all together. I will say that much because there was a lot of conversation going on. But just to draw your attention to that, and I wanted to run through it quickly just to see if anybody had any additional suggestions of things they either recall from the meeting that are not captured here or if you weren't able to participate, of course, that would be the case with Tim since he's a new member, if you have any other thoughts.

But this was a brainstorming discussion about those things that the implementation workgroup could or should be focusing on. So the first one was some discussion about how we might provide our input and/or our feedback on things that are going on at the ONC office. The discussion went that we knew there's quite a number of things that are taking place at ONC, and in fact, every other day or so, something new seems to be surfacing as to the availability of resources or such as was the case late last week, the new FAQ site, the idea that we would add to that by the recommendation of a publicly accessible, online reporter dashboard to track implementation practice.

So the idea here was, what's going on with meaningful use qualification? How many sites may be even listing the sites that have registered, if you will, as of January 1st, then the same thing about attestation following April 1st that those things be publicly available so that we can consider potentially using other sites as references for current implementations. Then, correspondingly, things with regional extension centers, the state programs to be … in the national health information exchange. The most important concept here was not to duplicate what is already existing, but rather, to make sure that, in one place, we could easily see what actually was available and not have to go searching at either the ONC Website, the CMS Website or, for that matter, the HITSP Website. So that was just the conversation there.

If you go to the next slide, here's where we talked about providing feedback and a reality test to things that are going on or being published from the policy committee or the standards committee's recommendations, and do these things make sense from an implementation standpoint? Maybe, for example, the conversation was, what about the quality measures? Do those seem to be working well, or are the measurements for the meaningful use criteria clear? Do folks actually have what they need to be able to go out and use that? There's a fair amount of conversation about NIST and whether the NIST test cases should be more specifically highlighted as a use for implementation and not just for certification. The next recommendation or thought about potential activities were to encourage and advertise the use of some of the existing resources, and here we were talking about the blogs and the FAQs.

Going onto the next slide, evaluating and considering use of social networking tools to connect with people and learn from other's implementation efforts, providing clarity on the meaningful use specification, and resolving confusion on any available resources. This kind of goes back to that number one recommendation as well. But the ability to maybe harmonize things by creating a playbook, providing guidance on how the meaningful use criteria fit or don't fit or don't have any relationship to, in some cases the NHIN and NHIN Direct. Then helping the providers and hospitals determine how to bridge efforts regarding meaningful use performance quality measures and the NHIN. The last one on this slide is to clarify consumer expectations of EHR vendor certification, and what they can actually expect when they are purchasing or have an existing agreement with the certified EHR product, and I'll have an editorial

comment on that one. Personally, that seems to be getting more confusing rather than less confusing right now.

The next slide, the second to the last slide here, consider a home for the questions that NIST is not able to answer and possibly a place to publish lessons learned. Ascertain, if it would make sense, to create a version of the NIST test scenarios for consumers. I mentioned that actually already. Then determine what drives our workgroup agenda and how we're going to measure our success. So that's that, and then there were a couple of next steps.

The first next step, we're already working on, although we don't have anything to show you today. And that is to get a list or make it clear what ONC and CMS already have planned and what they need our input or feedback on. Then we need to prioritize our activities, create a roadmap for working on them, adding a member for public health, which we've already done, and determining metrics for success.

Any questions on that from the first meeting, any comments? I know I went through it relatively quickly, but hopefully you got a chance to look at the slides before.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. I think, Judy, first of all, I think it's a great job, I think we're also asking the committee if there's something that you've either thought of since the meeting or a clarification that you'd like to add, this is a great opportunity to do that for us.

Lisa McDermott – Cerner Corp. – Sr. Architect
Judy, you did indicate that this was presented to the standards committee. Was there any feedback from then on what was presented?

Judy Murphy – Aurora Healthcare – Vice President of Applications
Yes. That's a good question. There actually was, and it was mostly, in fact, the overall comment was, how can we argue with any of this? It all makes a lot of sense. Of course, that is. We're in some cases, what I would call stating the obvious. What we got from them was a few additional comments, if you will, or thoughts of things that we could or should include. I don't know, Liz, if you've got your notes. I'm actually, quickly, looking for mine from the meeting.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. I have a few things that we talked about. They really wanted to make sure that when we, as we went through this whole process that we were really looking at making sure that the provider was adequately represented. I think that we're very pleased with the composition of the group. They wanted to know where was our greatest amount of focus, with the provider or with the vendor. I think we said, with the provider, but we have to keep an eye on the vendor. I think Judy kind of alluded to that. I know many of us are finding that the provider's ability to step up or how they're stepping up may not be optimal, so I think we have to keep a balance there.

They were certainly asking about, did we get in HIEs. Were we really looking at that? Best practices, limitations, and were we including not only meaningful use, but HIEs? They really liked the metrics component of it. I think that was well received, and really kind of looking at the value proposition for the user. I have several notes here. I'm looking.

They did ask about who was our consumer. That was the question about the vendor of the provider. Would we provide forums, which we'll be talking about later, in terms of the hearing for people that are actually actively either in the process of getting ready for meaningful use, going to attestation, and so on. Then there were some questions around HIPAA and security and those sorts of things. One of the members of our committee is a true expert, Dixie Baker, on security and HIPAA and that sort of thing, so she always keeps us going back to make sure that, as part of what you're providing, that's a consideration. That's a real quick list of the immediate notes that I took. Judy, I don't know if you had others.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I did find mine, and I think you captured them pretty well. You have this coordination of communications was emphasized by a couple of different folks that right now there are a lot of resources out there, but finding them and knowing when they're updated is tough. John Halamka in particular kind of focused on that one. Then he talked about the fact that he is going to be, for example, posting his experiences in getting CCHIT certified in his blog. Just send some thoughts through the group in terms of that's exactly what I think a lot of implementers are going to want. They're going to want to hear other people's experiences, and so there was just a little bit of reinforcement in terms of, boy, it really might make sense to see if we can catalog, if you will, other folks' experiences as well and make them as overtly available to others as John Halamka always makes his experiences.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. I think real life experience, we're both saying, and I think we've heard from you. People want to know what worked, what didn't work, and especially as it gets closer in, and people begin to attest, and then that kind of process. Anything that we're able to share in a public domain is going to be the benefit of everyone.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I think that wraps it up unless anybody has got any additional comments or questions.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Maybe we want to move into our concepts around holding a hearing in January, thinking that people are rapidly approaching that are working on actively what they're doing to get ready, whatever phase they may be in, and possibly begin to gather that information. I don't know, Judy, if you want to add to that.

Judy Murphy – Aurora Healthcare – Vice President of Applications
No, I think that's good.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes, and so we really want to hear from your because, as we put this hearing together, the workgroup will be engaged in that process, not only helping us find the appropriate folks to do the testimony for us, but also what kinds of questions do we want answered. This is an opportunity for us to brainstorm on that. We chose January because we believe, first of all, people are really getting their arms now around what this all means, and we want people to have done enough analysis within their own organizations or how they help other organizations so they can bring to us information that's either been tested or is ready to share with others.

From the workgroup, if you have that opportunity, and you were going to be organizing a group that would talk about what is the voice from our user, from our meaningful use implementers. Judy and I have shared with you that we're both on that journey. Can you suggest some topics or testifiers? Go ahead. Yes, please.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
What I was thinking would be neat since we've already got certified products out there. Is there an example set of people who will have already gone through the journey, so that we can just get their feedback with a certified product like a smaller provider, a large provider?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Because the reporting period has already started, right, towards the incentives?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics

We can get … Judy, you might want to talk about the journey of Aurora. That way, then I could contrast that to what we're doing, and maybe that will help not only answer Anne's questions, but for the workgroup.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Yes. October 1st is the earliest you could begin your 90-day measurement period for 2011 for stage one criteria. However, I don't think there are too many people that are actually able to start by then because of the kind of timing issue that we've got with the certification of the products. So it's become clear now through the FAQs that you cannot begin the 90-day measurement period without the certified product already being in use. I say that because there was some question about, well, could I start the 90-day measurement, and then if my EHR vendor gets certified by the end of the 90-day measurement, might that be acceptable? It is pretty clear now that that is not acceptable, and that the vendor needs to be certified before the start of your measurements.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right, and we just saw the first list of those people last week.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Right, and it was like dangerously close to October 1st, so I'm just going to guess that there are not too many people that were able to do that. But in addition to that, there was this whole issue of the earliest you can register with the CMS to say that you are going after the stage one criteria is actually January 1st. The earliest you could attest to having achieved it is April 1st. Now that doesn't preclude you from starting your 90-day measurements on any day between now and April 1st, for example. But again, I think they're not expecting too many people to start their measurements much before January 1st because of this kind of time lag between the certification of the product and your 90-day measurement period.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
I know a lot of us, as you think about that, and sort of, Anne, to build on, for us, we're not going to do our first round until October of next year. But what we're planning to do is have dashboards and all kinds of things in place to look at it. We're planning to collect, begin collection of data, whether it's on the quality set or whether it's on the utilization measures. We're starting to collect data in January of 2011 so that we can look at trends and how we're doing and make modifications and that sort of thing. But still, that information is pretty helpful to people.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Yes. Let me revise my request. I just would hate to miss the opportunity in January of learning about somebody's experience. So if there is somebody, some entity that has gone through part of the experience, would it be helpful to have a little bit of dedicated time there to just get some early, early feedback? I know it's on the bleeding edge, but still, I would hate to miss the opportunity.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
No, I think it's a great idea.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I do too because people will be in the throws of figuring out what they have to do. In my mind, I was thinking, maybe we would organize one of the panels. By the way, for those of you who are new to this process, when we have a hearing, typically we organize them around panels. There might be three or four or five people on a panel. Those panels typically represent different opinions of the same thing, and that panel is given a list of questions to answer. They each get X number of minutes to answer the question individually, and then the implementation workgroup and, of course, we do invite the standards committee as well to join us. Anybody from either the implementation workgroup or from the standards committee has the opportunity to ask questions of the panel. Then whatever, one, two, three, or four of them answer the question. The dialog is what is particularly useful and where we often make some additional strides in terms of understanding and providing input.

Again, it's a way of giving input to the ONC and to CMS about some of the sticky points and helps them kind of get a direction at times about what they could or should be doing for the future. I think your suggestion of people, Anne, who are in the middle of this process and are struggling with, what were their sticky points again? What did they have difficulty understanding? We could maybe do one around meaningful use criteria and one around the quality measures.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Yes. I think that anything that we learn early will maybe give us some laser focus on the next set of hearings.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right. Yes. I think you're right. If we got from those who have already registered, those who plan. Now obviously registration won't take place until January, but I think we'll be able to identify who the really early contenders are, and if we could get, like you said, not only a large, multi-hospital system, but if there are also small providers or small doctor's offices. In other words, we can go across the arena, and we can find representation, we would bring them in.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Great.

Lisa McDermott – Cerner Corp. – Sr. Architect
Would one of maybe the panels be focused on looking forward to stage two? What I mean by that is, I know that they're looking to increase thresholds and advance some of the stage one, and then add additional objectives to that. We're starting to kind of get glimpses of drafts, and we will have more this fall. Is it may be a good opportunity, especially for one of these that is earlier, to give some guidance on how successful the stage one objectives thresholds are and what the implications of the stage two drafts might be.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Lisa, I think it's a great idea. I could see NIST being involved. I could see the meaningful use workgroup out of the policy group being involved. When you say what the success in state one is, where would we get? I mean, I know that some of us are already creating dashboards, so we would be able to provide what we have. I mean, I know we would be willing. I know probably Aurora would be willing at least to show you how we're measuring it. I think what comes to my mind is would it be helpful to understand how people are actually capturing and planning to present that data beyond the attestation period.

Lisa McDermott – Cerner Corp. – Sr. Architect
Yes. I think, if you're able to tell already in stage one that there might be an area of adoption, whether it's with the system or change management, having them actually see before they finalize stage two, seeing some of those areas or where clarification still is kind of gray in interpretation, before we go and directly influence the thresholds might be of value to them.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. I know that we could tell you. I bet Judy's organization. I bet there are a lot of organizations that could tell you where we're already, not that we're not measuring it, but where we found it to be more difficult, maybe we could bring forward, and lots of people could bring forward their mitigation for that.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Let me ask Judy Sparrow. I think the train might have already left the station on this one. Do you know the timeline for the meaningful use criteria because I know they're going to put it out for public comment relatively quickly here?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. I don't know the exact timeframe, but it will go out quickly. Paul Tang's meaningful use workgroup has been working on it already, and they're going to be making a presentation on the 20th to the policy committee about their work so far. So I think we'll know a little bit more at that time.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Is there a timeline on the backend that you're aware of, similar to the state one, by federal regulation that it has to be out by this date? I don't think so.

Judy Sparrow – Office of the National Coordinator – Executive Director
I don't know it off the top of my head. I'm sure there will be. I know they're also planning to go out publicly for comments on it, so there'll be a lot of opportunity, but it's probably going to be a pretty tight schedule.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Both of you, are thinking for the workgroup that … let's propose that we get this out in the next 30 days, that actually the public comment would be opened and closed before we have the hearing?

Judy Sparrow – Office of the National Coordinator – Executive Director
No, I don't think within 30 days. No.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
It would not go out and … but I think the question that I'm asking is, if we were to get input at this hearing, would it be timely for their finalization of the rule?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, I guess I can't answer that right now, but that's a very good ….

Judy Murphy – Aurora Healthcare – Vice President of Applications
It feels like it's going to be too late, and we should focus on the implementation experiences. Now not to say, like Lisa has got a great idea that what we're actually doing is help informing them so they can make better judgments and assessments, as they put together the detail on stage two, particularly around the measurements. But I don't think we should be focusing on what the content of those state two ones will be.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
I think it's pretty important, whatever the content of stage two is. I think it's very important to get commentary from small practices about that. I do think it's important to think about the content because our job is the Implementation Workgroup, and if we're hearing from small practices that this is impossible, or that it's very, very difficult, it's going to be that much more difficult to implement this. So I think, to ignore the content would be a big mistake. Also, I just want to point out that the only organizations that are going to have dashboards or anything that they can provide are going to be large entities, and that the small physicians who make up half of the people in this country who are providing this care, they're not going to have any of this stuff. The likelihood of them being able to use dashboards from a very large entity is small. I'm just putting that on the table.

Judy Murphy – Aurora Healthcare – Vice President of Applications
You're suggesting something that I think we almost always try to keep in mind, but we sometimes don't have in our forefront, and that is that whatever we do in the hearing, we should make sure that we are representing both constituencies and everything in between, I suppose, but the very small provider practice, as well as the very large, integrated, delivery network. There will be separate challenges.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
But what I think I'm suggesting is that it wouldn't be so terrible to have one panel look at stage two.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Another thing that that's a suggestion, and it brings to my mind … back, as I've listened to all of you speak was, one of the things we did in the past, and I would hope that the market is now more prepared, is you're right about the analytics and how much ability that the small practices have to do and … or otherwise, much of an analytical kind of a look at things: the dashboard, some kind of a data aggregation,

whatever it may be. But do we, and this is a question to the group, do we have innovators out there that are recognizing that because I'm not sure that a physician that wants to attest isn't going to have to have some kind of document or evidence or something that says I can attest that I'm meeting the standard. Right?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
That's right. We're expecting our EMR vendors to provide us with the ability to do that.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Can we consider adding in maybe some HIE representation—not HIE, regional extension center representation, at least on their charter in terms of what are they doing for those smaller providers?

Judy Murphy – Aurora Healthcare – Vice President of Applications
I love that idea. Now one of things with the RECs, and I guess it's the same discussion that we just had with the stage two criteria. There are other forums for input on those things. I think those are two that we definitely have to take back to standards and try to understand what's already happening. In other words, for the regional extension centers specifically, there's a resource center. And that resource center is having some kind of ongoing interaction between all the different regional extension centers. So I'm assuming that, therefore, in my head, that they're getting input and receiving feedback and harmonizing and letting A know what B is doing, so B can learn from A. That's going to make sense. Is there a way we can augment that at all from a feedback standpoint? That's an outstanding question. I just plain old don't know.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
I think that we should absolutely have them. If we don't include that, I think their entire charge is to take care of the little guy, and I don't know. That's the major feedback loop, the major actual feet on the ground, major already funded distribution channel for help. We need to know what they're working on and maybe even given them suggestions on what to work on.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Maybe one of the themes that we hear kind of coming together, and we need to examine as a group is, what are the implementation needs of the small provider, and what tools do we have that could be afforded to them that would help them meet those needs.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
I would like to just say, what has been their experience with their regional extension center. I think that's pretty important. The other thing, I don't know how it works in other states, but for example, in Massachusetts, these are supposed to be helping the small practices, but we have IOOs in Massachusetts that include Fallon Healthcare, the BI Deaconess Physician Organization, Boston University Medical Center, Health New England Medical Center. These are not small, I mean, these are entities that are large networks. We're supposedly using the regional extension centers to help small practices.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I like that focus. What we're, I think, saying is use the hearing to get the provider input on their perception of how the RECs are working.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
Exactly.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Yes. I was thinking of it the other way around initially. How do the RECs think they're doing? I love this suggestion.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect

How about we have ONC testify as to what they have charged the RECs to do? The issue might be that they're not ready now.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, I was just going to say ….

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
But what are they being paid to do?

Judy Sparrow – Office of the National Coordinator – Executive Director
Right. We might want to have both the funders and even back to your earlier point, the certifiers also.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right, so you have sort of the full continuum of where all of this should be coming together. That's a great idea.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We're a REC in New Hampshire and also one of the IOOs that Joe was just mentioning. I think it makes a lot of sense to have it from sort of 360 degrees, and maybe one way to think about it is almost to do it by market, so you could have a couple of RECs and maybe try to get a couple of the physicians from the states that the RECs are in to have sort of a closed-loop conversation. Obviously that gets a little tricky too, but it would be good to be able to—sometimes that conversation back and forth of people who are involved in the same thing makes it very interesting.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Well, it makes it interesting.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
And can flush out a lot of issues.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right. I think you're right. I think that's what can happen is if it's managed well, it can bring to light things that we actually need to focus on in a very honest way.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
There's a segmentation that maybe we can think about, as we think about which RECs to bring in. For example, there are QIOs. There are some who are really just off and running. They've signed up 800 physicians like, I think, in Idaho and Mississippi where there's a QIO who already has a group of physicians they've been working with. Now to Joe's point, maybe that's not the small practice, and maybe that's sort of an issue to bring to light.

Then there's RECs that are sort of more of almost like a franchise or general contractor model like New York or Rhode Island or Massachusetts where they kind of have the REC, but they're basically contracting it out to a whole bunch of different organizations. That might be another model that we sort of look at as sort of representative of an approach and see how they're doing and have a little bit of conversation of which one seems to be working better for the small physician, for example.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes, and I think the concept of then you would bring a physician in that's being impacted by that makes for it to really add truth to the mix.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. The last thing I might suggest is with ONC—and I'm sure Matt Kendall is going to love this—but certainly have them come and talk about it, but also talk a little bit about where the HITRIC is and what that's been doing because we're a REC. We're the New Hampshire REC, and the HITRIC is sort of getting up and running, but it's still not fully up and running, and so some of the things that it's supposed

to do, they're going to get there, but it's not fully there. So it seems to me that that's a fair question for us as a working group to be asking. We appreciate the issues of getting something like this launched, but we've got meaningful use coming hard and fast at all these physicians, and what does that mean about their ability to really be able to accomplish this?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Are there other things that we would expect in terms of whether it's this panel or another one that we, beyond the RECs, that we expect are going to be helping the small providers? RECs are certainly the legislative answer. Then somebody said, and what about our EMR vendors, and what are they doing to prepare us to do actual attestation because we don't have the capability of doing deep analytics. So there's another potential contributor. We've got small physician providers, and we talked about also the early adopters and sort of what they are doing, what kind of feedback can they provide us, and so on, and then the concept of stage two criteria. Other ideas? Great. Really good input.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
One thing that's intrigued me a lot is this, and we've heard a lot about it in the standards committee, but the ONC S&I framework. They've put out a lot of grant work to help support the true interoperability. I wonder, is there anything we can do from an implementation group to help with that process? Is that them testifying to us? Is that us finding a way to get their work base out to all the people who are getting ready to work on meaningful use two, which is going to require much more interoperability?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
So you're kind of saying what it is, and then how do we potentially disseminate it?

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Yes. Does everybody know? I know we know from the standards committee, but does everybody know that this is one of the lynchpins to allowing for real interoperability? Where we might have been frustrated in our standards, where we couldn't name certain specific standards. I could be way off base, but I'm looking for comment maybe from my other buds from the standards committee.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Personally, I've heard more than I need to about the …. I'm just teasing. By the way, we shouldn't use acronyms without explaining. I don't know if everybody knows. It's the standards and interoperability framework, and it's been Doug Fridsma from the ONC that's most often been updating us. I think he said there were six contractors, Anne, if I remember, big, multimillion-dollar type contracts that have been awarded to different groups. In fact, I believe it was six different groups that would be looking at advancing the different pieces of the framework.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Seven of them.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Seven, okay. You're looking at your notes.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. Let me throw out a suggestion to the workgroup for consideration. Is the first step to bring Doug to this group or someone from the ONC to get us oriented into what? I mean, you're right. There are seven groups, and I know all of us were kind of—forgive the term—scratching our heads going, what are all these people doing? There certainly was some explanation of it, but it's still trying to translate that into how does that help our providers get to where they need to be? Do we start with an education of this group?

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Yes, and maybe that's it. But several things have been converging for me that are going to be a big issue. One is meaningful use is going to require more interoperability: the two-way versus the push, that kind of thing. The technical transmission, the transmission standards are going to be a bigger topic.

People will actually now have to start connecting HIEs to Allscripts or vendors that are distributed out there to individual providers or to large hospital systems in order to get that integrated, electronic health record.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
One of my concerns—and I'm sure it's a concern of many physicians who are out in places that are relatively rural—is that even if they've got EMRs that are capable of doing all this stuff. They don't have bandwidth in which to use it so that they can accomplish the tasks that are necessary. They don't have those kinds of Internet connections.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Yes. John Halamka, just on his blog, just did that wonderful post about what does the patient who's naked and unconscious in the ER, what did all this do for that person. He mentions it's meaningful use two and three are where that's going to come together, and I think it's the standards and interoperability framework. I just wonder. Maybe the whole issue is getting us maybe a deeper level of education than the briefings we've received at the committee level.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. Maybe if we did that as the first step, and then as a workgroup, we could then say, now that we understand it in a more conversational way, then can we then discover who we need to find out? Is it that we need to get the information out there, or do they already have it, and they need to come and tell us how it's working? Judy, what do you think?

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
I think that's what I need.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I'm just hesitating as to whether that's a second hearing as compared to the first hearing.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Maybe that's not a hearing at all.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. That's what I wrote down, Judy. I thought maybe what we could start with was educating this group, and then not in anticipation for being prepared for the January hearing, but go in from there. That's what I was hearing. Does that meet the need of the group?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
Yes. That we would get that education before the January hearing.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right, but that we wouldn't necessarily— So I'm struggling, and others, I'm trying to keep us so that we can, when we're finished, we're able to report back what we want to do so that we can begin to organize it. We could certainly do the education if we can get Doug before the January hearing, but then what is the director correlation to the hearing itself?

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
I don't see a direct correlation. I was thinking that would be an opportunity, but I couldn't crystallize it, so I'm totally convinced it's not the hearing issue. It may be after we're educated, but certainly not yet.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
That's a good thing to keep in mind, I think, for an upcoming meeting.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Yes.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Other kinds of things that we think we could use in terms of a panel format to make sure that we're hearing from the meaningful use implementer? We talked about the small providers. We talked about the early implementers.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
I thought you had a full day's worth of stuff already.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
You know what? It's always possible, once we get started, we do. I just want to make sure, and I know Judy does, that we get the concepts out there.

Judy Murphy – Aurora Healthcare – Vice President of Applications
The only thing we didn't talk about, and I would be interested in input, do we want to have a vendor panel that would talk about the certification process because I suppose we do have accountability, if you will, to give some feedback on that as well.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
There is a certification workgroup. I don't know what's happened to it, but I know it's still there somewhere.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
The other thing I was thinking about, as you all were talking is how the vendors are doing, but I thought, and we also had, another thing like what John Halamka has to do at Beth Israel because he's got to get everything certified because he's built a whole system full of many parts. But we have to get a couple of products here certified that are proprietary, and I'm wondering what that process looks like and if others have to do that. I'll give you an example because I think it's easier to understand when it's not in concept form.

Our ADT system, patient accounting system, is homegrown. Because the rule is very clear that if you not only can read, but modify, and we do not modify in our clinical system. We modify in our ATD system. According to the rule read in absolute black and white, we need to get that system certified. So the question becomes, we're kind of working through the regs and trying to understand what that means to us. I would suspect that others are as well. I can tell you that as I've talked to other organizations, hospitals and CIOs that are going through this, some of this they haven't thought about. Some they have thought about, but they're really not at all sure what to certify.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Let me go back to Micky's comment real quickly. I think it was you that mentioned about the certification workgroup.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That was Joe, but I'm on the certification workgroup.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Yes. I was just going to say. There has been some discussion about merging the certification/adoption workgroup of the policy committee with this implementation workgroup because there is some overlap. I believe, right now, that the certification adoption workgroup of the policy committee has not meet for a number of months. Is that accurate?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
That's correct.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Yes. I think that's because, again, their charge kind of got done for a period of time, and they're relooking, or at least the chairs are relooking at what's going to be the new charge. I think that we could touch base with, who is it, Paul Egerman and I'm trying to think of the other person.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. Marc Probst.

Judy Murphy – Aurora Healthcare – Vice President of Applications
See if they would like to dovetail onto this hearing, and if that would be the case, then of course it would make sense to probably get some input or feedback on the certification process now that it's live.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. I think it's a great idea.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes, I do too, especially vendor and self-certification as well.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Exactly.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Yes. That's a great panel.

Judy Murphy – Aurora Healthcare – Vice President of Applications
It makes me think also about … we looked into self-certification and, boy, you go out to the Website, and it's like impossible to determine how much it costs or ….

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. We did too.

Judy Murphy – Aurora Healthcare – Vice President of Applications
We were trying to say, do we just give up the product or do we certify it, and we thought, let's just get DataPoint. How much would it cost us to get certified and what would the process be? All we found on both sites were these big applications. We didn't find, well, we're going to have to do a site visit if you're this kind and it'll be this much money, so at any rate.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. We kind of got it was $35,000 to do the initial application, but that's not good enough for us. That's not all in.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Yes. At any rate, that's the kind of stuff I suppose we could maybe have three vendors and two … certifiers or something.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. You know Joe or the others, going back to the small vendor, if you have a small provider, if you have a homegrown EMR, I haven't looked at that all. I don't know if you have, Joe, Judy, or others, and if that's a place where we need to be providing experience. What are you experiencing? Are we doing that? Without a list of who is doing what, which is sort of where we want to go as a group in the end is sort of understanding what the trends are. I don't know if that's something people are seeking. Joe?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
I was just going to say, I doubt that there are very many small practices with homegrown EMRs. I'm sure there are some, but I think that they're probably very, very few and far between, and they're probably looking at vendors now themselves.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. I agree with that.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Are we talking about an EHR or an EMR? You keep throwing EMR out there, and a lot of things that I do we're really certifying an EHR, not an EMR, right?

Judy Murphy – Aurora Healthcare – Vice President of Applications
I don't think we're differentiating that term. We're using the term electronic health record to mean whatever they have.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
There is a definition within a Pub that came out of HHS that defines the three things: PHR, EMR, and EHR.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
But some people are combining an EMR with other vendors to achieve meaningful use.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
But it gets confusing like John Halamka talks. He talks about a CCR and CCD that's within their four walls of their building, you can have whatever you want. It's when you go outside the four walls that we recommend the CCD, and that's where you've got to have certification and have standards. When I give my talks about there, it sometimes gets very confusing when somebody starts interchanging EMR and EHR.

The second thing, I'm a commissioner on CCHIT, and I know that they would be very happy to speak to this group on all the differences because they're not just doing an ARRA certification. They're doing a full certification that some of the vendors, a lot of them got approved here last week, will be using as a marketing tool to say, why just get an ARRA certification? Why not get a full certification?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
That's good input. I think Judy is right. I know we use and interchange it because we pick up components of them across the organization. We know we're going to have to have a PHR, and we recognize that's separate from the document related to the care provider inside of a provider or a doctor's office. But at the end of the day, it's all of them combined.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
I would be very happy to send it to you because I send it to everybody so they can get it straight … vocabulary that Jamie is working on is so important, at least I think so, that we're all talking the same words and the same meanings for those words.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Sure.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Sorry to ….

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
That's all right.

Judy Murphy – Aurora Healthcare – Vice President of Applications

No. You know why I think no one has actually adopted those definitions, because HIMSS made a stab at that five years ago, is the EMR, which is meant to be the inpatient if you will or within the walls, that differentiation is artificial because we have community physicians who dial in and use that record. We have pieces of that record that end up being used in ambulatory and surgery centers and actually go into personal health records. So it almost seemed artificial to create that difference, which is why I think the industry hasn't latched onto it.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Let me give my …. Us good guys that look at people for days, months, and years, the EMR in a long-term care, let's say … as an example, could be like years. You don't put all that in an EHR, so the differentiation when you get beyond an episodic situation is because you don't want an EHR everything that went on in even the episodic: all the temperatures, the blood pressures, and everything that's probably in an EMR. You don't really want to transfer that to an EHR.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Again, people don't have two different vendors, and vendors don't have a purge and archive strategy, and so they end up being the same thing, but I don't think we should spend any more time on it anyway. Conceptually it makes sense, but practically it doesn't play itself out.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
John, I have to admit that when you started to speak, I was ready to hear about long-term care, so you caught me by surprise, and that's a good thing.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
Remember, I used to work for you guys. I do know episodic and hospitals.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
You do.

Judy Murphy – Aurora Healthcare – Vice President of Applications
No, and your point is actually well taken. What do you need for clinical care versus what's the legal medical record that needs to be archived. Yes.

John Derr – Golden Living LLC – Chief Technology Strategic Officer
So many times we forget the whole goal is person-centric longitudinal care.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right. Judy, what we may want to do because I don't want to have us run out of time before we get to the last topic. Do we want to move on and talk about kind of communications? Judy and I both shared with you that just as you expressed your concern about the communication really improving and being easier and so on. We talked about that we really want to make sure that this group is focused on, and how do we begin to move that from just the concept that we all agree to, to some actual activities of how we … implementers. If somebody else has a panel thing, I'm certainly not trying to shut that down. I just don't want to miss the last topic if we want to get to it.

Judy Murphy – Aurora Healthcare – Vice President of Applications
It sounds like we're ready to move on, and I think you recall, I have to drop off in a few minutes.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
I do. What we'd like from you, as we work together as a group, is you heard us talk about that we've all identified that our communications and where you get information and how we really insure that even if we were able to create a space where people could easily navigate and find what they needed, how do we know what they need? I think the hearing was certainly one way of beginning to get that information, and we wanted to have the workgroup give us input into others, or we could talk about even how we navigate. I think, again, I want to reiterate, we've talked with the ONC folks and said, we really need to understand what you're going to be doing, where your information is going to be, and so on, so that we

can share that back with the implementation group and then make sure it gets sent out to the public in a way that's understandable.

Ken Tarkoff – RelayHealth – VP & General Manager
One of the ideas I had for that is potentially similar to the way that we ask for comments when we release information like on stage two. I wonder if we wanted to do something more formal where we actually ask for questions from the market on what are the questions that people are running across that they are looking for answers to. We could make it a more formal process and then get an aggregation of that information, and so we can actually see what are the type of questions that we're seeing from the market and the different areas to make sure that we then know what people are asking and how easy it is for them to get access to the answers to those questions.

Judy Murphy – Aurora Healthcare – Vice President of Applications
That's a great idea, by the way.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
It is because I think that way, again, we're doing exactly what we're focused on, which is asking you, the user, or you the implementer, what do you need. What do you not understand …? It was before, and I don't know if this is satisfactory or not, once before that was the place where we really were able to use our blog space. I don't know if that is tasteful or distasteful. We saw some real intensive use of it, and then it diminished pretty significantly.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I think if we ask the right questions or sort of lead people to give us the information that we're looking for, in other words, just don't make it a blank slate. We have to think up some questions or comments, and we'll elicit a response. We can certainly use it.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
That's one tool. Other ideas there? Again, I think, Ken, you're absolutely right that we really do want to answer the questions they want answered. Often when we guess what they want answered, then we miss it completely.

Ken Tarkoff – RelayHealth – VP & General Manager
Liz, are you asking about the mechanism for which you would use to ask it?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes.

Ken Tarkoff – RelayHealth – VP & General Manager
What I was wondering, what I was trying to suggest is if you did something to the extent of just made a public request and asked for people to submit questions within a period of time, and gave some guideline onto what we specifically want to know, what they need to understand better, whatever vehicle they wanted to deliver it in.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes.

Ken Tarkoff – RelayHealth – VP & General Manager
I think a lot of people would respond to that. I think, if we publicized it appropriately, we could get access to all the different areas that we want response on, so we're not just hearing in one area.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Exactly.

Ken Tarkoff – RelayHealth – VP & General Manager

If you think about how many people respond to policy or standards comments, if we could do something similar, I think we'd get good feedback, even if we just made it open for them to submit it.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. One of the things that we were watching recently was even on Twitter, during meetings, people are asking questions. I think people are very tuned into this.

Ken Tarkoff – RelayHealth – VP & General Manager
Yes.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
I'm writing notes. Other suggestions? Does the other participants in the workgroup … see value in this one. Maybe we frame our next step around first framing what the questions actually are. It's a very good point. I know you're out there.

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
… concurring.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Silence is affirmation, correct? What I'm going to do then, and then we'll pause again. I'm going to kind of go over some of the things that we've been talking about to make sure that we've captured all of your input. It's really valuable, and we're obviously trying then not only to do this for future planning purposes so that we could take back to the standards committee what we talked about. We really have, we've done some considerable work around panels, and there appear to be at least, I think, five panels and how this worked in the hearing, in the recent hearing, and that sort of thing. We'll frame it up and bring it back.

One is really around RECs and really looking at what is the ONC charge to our RECs, and what do they believe they're delivering. Then I thought it was a terrific solution to look at RECs in terms of those that are franchised and those that are associated with QIOs and how they're delivering it. Then hear from our providers how those services are information being utilized and what kinds of input can they give us into what they're using that information or service for to implement and what they still need.

Then we had a discussion around stage two meaningful use criteria and what, sort of informing that, Lisa talked about where the NIST might be. I know we talked a great deal about that the meaningful use group is out of the policy committee is closing in on having public recommendations that would then go to public comment, and so we'll look at the timing of that. Again, recognizing, as we did last time that we had a hearing, that those persons who are already beginning—at that point, they were very focused on stage one. But I think we're anticipating, as fast as we can understand and do have some insight from the July 28th federal postings, what stage two requires, how we will prepare.

We talked about early adopters and no matter how early they are, and even given the timelines that we have to adhere to around first saying we want to register, a second saying we can start to attest. What are they doing? How are they getting there? What are they learning? What can they share with others?

We had a really good conversation around the interoperability, and I think came to the decision that we really need an education for this workgroup, so going back to the panels. Then we also talked about a vendor panel, really kind of intertwined, and so we'll have to do some sort of teasing this out around the certification process. Should we be working with the adoption and certification workgroup? How can we join our forces together to get that kind of information from us?

Then, as we begin to talk about really understanding our implementers, we talked about this really good concept of how could we go public and get some variety of participants. What is it that you want us to know about implementation? What do you need help from us with? Really give us sort of that insight, so then we can clearly hone our efforts and plans to meet the public's needs. That's kind of sort of an encapsulated view of what I've sort of jotted down through the course of our discussion. Have I missed something? Are there other things you'd like to add?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
I understand what you just said, but I'm wondering whether it's our job to help people implement, or is it our job to find out how they're doing on implementation, find out what their needs are, and then transfer that information to somebody else.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
I'll throw out my view on that, and then I'd like to hear from others. When I say I think we need to find out how they're doing. That's our number one job. When we talk about helping them, I think we're back into the concept of are there toolkits, plans, guidelines, case studies, real life experience that we can put out in the public domain that will help them meet their goals, not that we would do it for them. Does that make sense? But that we would be a gathering place, a place where synergies could take place so that what we do know can be shared. How does that seem to you, Joe?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
It seems fine to me that somebody should do that. I'm just not sure that it should be the workgroup that does that. I guess that's my point.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
That's a good point. Judy Sparrow or Mira, you might want to lay in on this. One of the things that we started last year, and we made some traction, but not as much as we want, is that we'd really turn to the ONC and ask. Even at one of our recommendations was a librarian or somebody where as a vendor or a provider of whatever size had a tool that they thought would help others and that could be connected in a very navigable way from the Website, that it would become available to them.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, and I think that's one of the contracts, and I'm not sure where it is. I don't think Doug is on the phone, but I think that's one of the contracts that Doug had out or will be getting out as far as a librarian goes. But certainly, I think, what the workgroup can do is make recommendations to ONC on what we can do. I mean, you can certainly investigate what the lay of the land is, and then recommend what might be helpful to us to sort of increase the implementation. It's a little bit of a two-edge sword because, on one hand, ONC has obviously got a lot of projects out there in the field, and we need to let you know how those are going before you can really delve into that particular task, so it's a chicken and egg thing.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Maybe you want, Joe … maybe one of the things we need to do, Judy, for a future meeting is that's another topic where if indeed one of the contractor grants is so that we would have that capability. The workgroup says we want you to do this. You come back and say, this is how we're going to accomplish that. Then we, through the—I do think though that in the past at least we've been a vehicle to, at minimum, promote the sharing of best case scenarios and toolkits and that sort of thing. You're right, Joe. I think it's not our job in a formal way to make those available to the public. Is that your point?

Joe Heyman – Ingenix – Chair, National Physician Advisory Board
Yes, that was my point.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
That's a good point.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
But I think that the S&I framework thing with that contract, which I think is one of the contracts was done because of our input from last year's work on the workgroup.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
I do too.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect

Yes, this past year's.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Right. We did make a formal recommendation, and that's why it will be interesting, Judy, to know if they have let that contract—that they needed a formal person to manage information coming in so that it was going to be easily available to those who want to take advantage of it.

Mira Choi – ONC
I just wanted to add on to what Judy had said. We could have Doug come in and do an update on that in the next workgroup meeting. If that would be an interest for everybody there, we could talk about that.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Mira, would he do both? Would he do interoperability, and then can he also or can you bring to us what the other contractors are going to be doing?

Mira Choi – ONC
Yes. Sure. We could do that. Definitely.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Yes. That would be helpful. Is that something the workgroup is in favor of, so we could make that plan?

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Absolutely.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
So you know, guys, that's how it works. If you don't speak out, that's going to be on the next agenda.

Anne Castro – BlueCross BlueShield South Carolina – Chief Design Architect
Everybody must have said absolutely.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Okay. Other comments in closing that you'd like for us to take into consideration because, again, we will put this all together? I'll put this together, and we'll present it back to the standards committee. Then we do have our next meeting planned.

Judy Sparrow – Office of the National Coordinator – Executive Director
Right. It's November 4th, 2:00 to 3:30.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
There you go, so before we open it up for public comment or question, anything else from the workgroup? We'll be silent for a few minutes for you to chime in.

Judy Sparrow – Office of the National Coordinator – Executive Director
Maybe I should ask the operator to see if anybody from the public wants to make a comment.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
That would be great. Thank you.

Operator
We do have a public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Please state your name and your organization, and there's a three-minute limit.

Shelly Spiro – FASCP – Director

Hello. My name is Shelly Spiro, and I'm the Director of Pharmacy EHIT Collaborative, a newly formed collaborative of nine of the National Pharmacy Associations. Our members practice in all settings including, but not limited, to hospitals, community, long-term and post acute care such as skilled nursing facilities, hospice, homecare, assisted living, universities, health systems, and ambulatory care clinics. The collaborative is focused on insuring that technical standards are aligned with the nation's growing need for all inclusive clinical services provided by pharmacists in all practice settings.

The services provided by pharmacists, especially administering and providing immunizations and medication therapy management services are integral to all providers using the electronic health record in a meaningful way. Pharmacists play a key role in the prevention of adverse drug events and medication reconciliation to assure medications are safely used in all practice settings. The pharmacist electronic health record has been developed and validated through the standards development process, both of the organizations NCPDP and HL-7. In the near future, we'll be going through the certification process.

Pharmacists have the ability to move past the record keeping aspect of prescription processing to provide a fully integrated, clinical, electronic health record. The pharmacist EHR will integrate with other providers' EHR and the patient's personal health record eventually to assure the practice improvements provided by pharmacists related to safe medications used is achieved. The collaborative has pharmacist members involved in the state health information exchange and the regional exchange centers initiatives. The pharmacy EHIT collaborative is ready and willing to assist the implementation workgroup with information related to the pharmacist's role, as clinical providers into the bidirectional exchange of clinical information outside the electronic prescription process. Thank you very much for allowing me to comment this afternoon.

Judy Sparrow – Office of the National Coordinator – Executive Director
Do we have any other comments? Okay. Liz, I'll turn it back to you.

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Thank you, all, for your time and great input into this. We'll look forward to getting together next month. In addition to having Doug, we'll also have laid out a framework for a hearing and continue that. We'll have those documents out to you in advance of the meeting so you'll have your input ready. With that, thank you to all, and we'll talk to you very soon.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Bye-bye.